OCTOBER 2022 HIGHLIGHTS

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Defendant Charged with Fraudulent Receipt of VA Funds

A multiagency investigation resulted in charges alleging that a defendant fraudulently received VA funds intended to reimburse a not-for-profit integrated healthcare system for community care provided to veterans. It is alleged that the defendant also fraudulently received funds from a public school system, a deposited counterfeit check, and loans from the Small Business Administration, and then split the funds with coconspirators. The loss to VA is approximately $750,000. The defendant was charged in the Southern District of Florida with wire fraud. This investigation was conducted by the VA OIG, Homeland Security Investigations, Federal Deposit Insurance Corporation OIG, US Secret Service, and Aventura Police Department.

Owner of Compounding Pharmacy Pleaded Guilty in Connection with Compounding Pharmacy Fraud Scheme

Another multiagency investigation revealed that a pharmacist who owned a compounding pharmacy billed more than $37 million to multiple federal healthcare programs for compounded medications that were dispensed through an illegal kickback scheme. The federal programs included CHAMPVA (supporting veterans, service members, and their families), TRICARE, and the Department of Labor's (DOL) Office of Workers' Compensation Programs. Of this amount, the pharmacist received payments totaling approximately $22 million. The loss to VA is approximately $524,000. The defendant was sentenced in the Southern District of Texas to 27 months in prison and three years of supervised release after previously pleading guilty to conspiracy to pay and receive healthcare kickbacks. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), US Postal Service OIG, and DOL OIG.

Benefits Investigations

Former VA Employee Indicted for Theft of Government Funds

According to a VA OIG investigation, a former employee at the VA regional office in Bay Pines, Florida, opened a joint bank account that listed a friend, who is a veteran, as another accountholder. The former employee allegedly directed the veteran's VA compensation benefits—which were awarded

without the veteran's knowledge—to be deposited into this joint account. The defendant allegedly used the funds for his own expenses. The loss to VA is approximately $568,000. The defendant was arrested after being indicted in the Middle District of Florida for theft of government funds.

Featured Investigation

Co-owner of Diving School Pleaded Guilty in Connection with Education Benefits Fraud Scheme

A VA OIG proactive, data-driven investigation revealed that the co-owner of a for-profit, non–college degree diving school made false representations to VA about the school's compliance with the hours of instruction for each of their VA-approved courses, attendance and course completion dates, and payments received from non-VA students. To qualify for Post–9/11 GI Bill funding, a school is required to certify that no more than 85 percent of the students in any course are receiving VA benefits. This requirement, commonly referred to as the "85/15 rule," is intended to prevent abuse of GI Bill funding by ensuring that VA is paying fair market value tuition rates since at least 15 percent of the students would be paying the same rate with non-VA funds. To evade compliance with the 85/15 rule, the defendant conspired with others to establish a fake scholarship fund that was ostensibly to pay for non-VA funded students enrolled in VA-approved courses. The scholarship did not pay any funds, and instead non-VA funded students were allowed to attend classes for free or at discounted rates. The loss to VA is about $3.2 million. The defendant was sentenced in the Southern District of Georgia to six months in prison, three years of probation, and more than $3.2 million in restitution. To date, three other defendants pleaded guilty in connection with this investigation.

Co-owner of Another Diving School Pleaded Guilty for Role in Education Benefits Fraud Scheme

According to a separate investigation initiated by the VA OIG in coordination with DCIS, the co-owner of another for-profit, non–college degree diving school made false statements to VA about the school's compliance with the "85/15" rule, the hours of instruction provided to enrolled students, the dates of attendance and completion dates for certain students, and payments received from non-VA students. The loss to VA is approximately $1.1 million. The co-owner pleaded guilty in the Southern District of Georgia to making false statements.

School Recruiter Sentenced for Involvement in Education Benefits Fraud Conspiracy

A third proactive investigation by the VA OIG revealed that a recruiter for another for-profit, non-college degree–granting school and their coconspirators fraudulently submitted false information to VA regarding the education services provided to Post–9/11 GI Bill beneficiaries. Between November 2015 and September 2020, VA paid more than $1.7 million to the school and more than $1.3 million to the school's enrolled veterans and other VA beneficiaries. The recruiter was sentenced in the District of Columbia to one year and one day of incarceration, two years of supervised release, and restitution of more than $1 million that will be jointly paid with the other defendants in this case.

Veteran Admits to Role in Life Insurance Fraud Scheme

An investigation by the VA OIG, FBI, and Naval Criminal Investigative Service resulted in charges alleging that several coconspirators submitted fraudulent claims through the VA-administered Traumatic Servicemembers Group Life Insurance (TSGLI) program. The scheme involved submitting TSGLI claims that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living, generating payouts of $25,000 to $100,000 each. The loss to the TSGLI program is approximately $2 million. One defendant pleaded guilty in the Southern District of California to conspiracy to commit wire fraud. To date, eight other individuals have been convicted in connection with this scheme.

Former VA Fiduciary Sentenced for Misappropriation of Husband's Benefits

Another VA OIG investigation revealed that a former VA-appointed fiduciary misappropriated funds intended for her husband by spending the money on methamphetamine for herself and others, living expenses for five other people, vehicles for numerous individuals, and other items not for her husband's benefit. The fiduciary was sentenced in the Eastern District of Arkansas to 20 months in prison, three years of supervised release, and restitution of $143,000 after previously pleading guilty to misappropriation by a fiduciary.

Investigations Involving Other Matters

Two Defendants Charged in Connection with COVID-19 Fraud Scheme

A multiagency investigation resulted in charges alleging two defendants submitted fraudulent applications for Coronavirus Aid, Relief, and Economic Security (CARES) Act funds for several purported nonprofit religious organizations and related businesses. The defendants allegedly spent the funds on renovations of their various properties as well as on luxury items. The total loss to the government is approximately $3.5 million. The defendants were arrested after being charged in the District of Massachusetts with conspiracy to commit wire fraud and unlawful monetary transactions. This investigation was conducted by the VA OIG, FBI, and the Pandemic Response Accountability Committee Fraud Task Force.

Former VA Accounting Technician Sentenced for Producing and Possessing Child Sexual Abuse Material

A former accounting technician at the Orlando VA Medical Center in Florida used his VA-issued computer to solicit and receive sexual content from a 13-year-old victim. The defendant was sentenced in the Middle District of Florida to 35 years in prison and 15 years of supervised release, and was ordered to register as a sex offender after previously pleading guilty to sexual exploitation of a child and possession of child pornography. The investigation was conducted by the VA OIG, FBI, and the Orange County Sheriff's Office.

Nonveteran Sentenced for Drug Delivery Resulting in a Veteran's Death

A nonveteran sold fentanyl to a veteran residing in a homeless shelter located on the grounds of the VA

medical center in Butler, Pennsylvania. The veteran subsequently died in his room from a combined drug poisoning, to include fentanyl. The nonveteran was sentenced in the Butler County Court of Common Pleas to 66–144 months in prison after pleading guilty to drug delivery resulting in death. The VA OIG, VA Police Service, Pennsylvania State Police, and Butler County District Attorney's Drug Task Force investigated.

Veteran Indicted for Threatening VA Employees

Between November 2020 and May 2021, a veteran allegedly sent more than 100 text messages in which he threatened to assault and murder employees at the VA medical center in Bay Pines, Florida, and their families through the use of explosives and aerial delivery devices. The veteran was indicted in the Middle District of Florida on charges of interstate transmission of threats to kidnap or injure. The VA OIG and FBI Joint Terrorism Task Force conducted this investigation.

Son of a Veteran Indicted for Assaulting a VA Registered Nurse

A VA OIG and VA Police Service investigation resulted in charges alleging that the son of a veteran physically assaulted a VA registered nurse who was providing medical care to his father through a home-based primary care program administered by the Louis Stokes Cleveland VA Medical Center in Ohio. The son allegedly punched the nurse in the face without provocation or warning because he was angry that she was inside his father's residence. After the nurse fell to the ground unconscious, he allegedly punched her again in the head when she tried to get up. The nurse escaped the residence and was transported to the emergency room with multiple injuries. The defendant was indicted in the Cuyahoga County (Ohio) Court of Common Pleas on charges of felonious assault and assault on a healthcare worker.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Its work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The Office of Audits and Evaluations released the following reports this month.

Healthcare Access and Administration

Additional Actions Needed to Fully Implement and Assess Impact of the Patient Referral Coordination Initiative

This review evaluated VA's implementation of the Referral Coordination Initiative (RCI), a program designed to improve veterans' access to quality care at VA facilities and community care settings for veterans eligible under the MISSION Act of 2018. In 2019, the Veterans Health Administration (VHA) began implementing the RCI at 139 VA medical facilities and set a completion deadline of June 30, 2021. Based on interviews with leaders and four facility site visits, the OIG made seven

recommendations with which the under secretary of health concurred. Among the findings were that, as of June 2022, no facility had fully implemented the RCI for all specialties. Facilities struggled with implementation due to insufficient staffing and resources, unreliable data on community care wait times, lack of required training, and confusion about which of two implementation models to apply. The program office responsible for overseeing the RCI also lacked the ability to monitor progress due to insufficient data.

Review of VA's Staffing and Vacancy Reporting under the MISSION Act of 2018

The OIG assessed VA's compliance with MISSION Act requirements for reporting staffing and vacancy data, and the clarity of related explanations, on its public-facing website. Because VA corrected its time-to-hire calculation and explained OIG-identified discrepancies in its June 2022 report after discussions with the review team, the OIG did not make recommendations for additional action regarding this issue. VA also took corrective action in response to the review team identifying that VA could strengthen its explanation of vacant positions to show the data were rounded and included part-time positions. In considering the team's feedback that VA could increase the value of reported information by summarizing and identifying trends, VA added information to a data summary tab. The OIG made two recommendations that include potentially requesting legislative relief from Congress on data it is unable to report, or otherwise ensuring data limitations are clearly explained that preclude VA from reporting all elements of time-to-hire data under the Veterans Health Care and Benefits Improvement Act.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. While the OIG selects and assesses specific areas of focus on a rotating basis each fiscal year, it also reviews broader issue areas, such as VHA facilities' leadership performance. The results of these evaluations are published in CHIP summary reports. Four CHIP summary reports were released this month, which describe observations from healthcare inspections performed at 45 VHA medical facilities from fiscal year (FY) 2021. Each inspection involved interviews with key staff and reviews of clinical and administrative processes.

Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021

This summary report evaluates VHA facilities' high-risk processes, focusing specifically on selected requirements for managing patients' disruptive and violent behavior. The OIG found general compliance with many of these requirements but identified weaknesses with—and issued three recommendations related to—required members' attendance at disruptive behavior committee or board meetings, patient notification of Orders of Behavioral Restriction (a restriction on the time, place, and/or manner of proving a patient's medical care), and completion of required training.

Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2021

The OIG FY 2021 evaluations of VHA facilities' mental health programs examined suicide risk screening and evaluation processes in emergency departments and urgent care centers. While the evaluations found general compliance with most of the selected requirements, the OIG identified a weakness with the completion of mandatory training by staff who develop suicide safety plans and issued one recommendation for corrective action. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide.

Evaluation of Leadership and Organizational Risks in Veterans Health Administration Facilities, Fiscal Year 2021

This report on VHA facilities' leadership and organizational risks spotlights executive leadership position stability and engagement, budget and operations, staffing, employee satisfaction, patient experience, accreditation surveys and oversight inspections, factors related to possible lapses in care, and VHA performance data. The OIG did not issue recommendations but developed this summary report for the under secretary for health, Veterans Integrated Service Network directors, and facility senior leaders to consider when improving operations and clinical care at VHA facilities.

Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2021

The OIG inspected VHA facilities' quality, safety, and value (QSV) programs that focused on facility committees responsible for QSV oversight functions, systems redesign and improvement programs, protected peer reviews of clinical care, and medical center surgical programs. The facilities generally complied with many of the selected requirements, but the OIG identified weaknesses with protected peer review and facility surgical work groups and issued three recommendations. These related to peer review committee documentation of individual improvement actions for level-3 peer reviews, surgical work groups that meet at least monthly with consistent attendance by required members, and surgical work groups' monthly review of surgical deaths.

Featured Hotline Cases

The OIG's hotline staff accept complaints from VA employees, the veteran community, and the public concerning criminal activity, waste, abuse, and mismanagement of VA programs and operations. The following is a case opened by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

Patient at Wilmington, Delaware, VA Medical Center's Community Living Center Experienced Harmful Complications While Eating as a Result of Dietary Errors

An anonymous complainant alleged that a VA community living center (nursing home) patient in Delaware experienced complications and subsequently died. Hotline requested the CLC review the matter and provide a response. The CLC's independent review found the patient was initially on a special diet (minced and moist food) and was observed during all meals to avoid choking or aspiration. When the patient returned to the CLC following hospitalization (where a different diet was employed), the patient's special diet was not reinstated. The patient's roommate found the patient choking and alerted nursing staff, who responded and suctioned food from the patient's throat. Later the same day, the patient developed signs and symptoms of respiratory distress. The patient expired after developing aspiration pneumonia (a lung infection caused by inhaling food, liquid, and other matter) and oxygen deficiency. An institutional disclosure was made to the patient's family, and the CLC implemented corrective actions that included

- standardizing a process for promptly reassessing a veteran's care plan when returning to the CLC,
- implementing CLC staff annual training (with case studies and simulations) on patients with difficulty swallowing and feeding assistance, and
- requiring the nurses to complete the templated nursing transfer summary note in the computerized patient record system when sending a resident to the emergency department.

***

To listen to the podcast on the October 2022 highlights, go to www.va.gov/oig/podcasts.